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Everybody's Working (But the Weakened):

An Assessment of Medicaid Work Requirements and Their Administrative Burdens

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Spring 2019 Capstone Project

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Executive Summary

Although Medicaid work requirements are currently halted in both Arkansas and Kentucky, this analysis utilizes the data available to make an assessment and estimate of what Kentucky's Medicaid enrollment will look like if work requirements similar to those Arkansas had are ever implemented. The relative severity of the administrative burden of such requirements provide a tool for comparison, and a difference-in-differences analysis of the change in Medicaid enrollment between Arkansas and West Virginia, a state that has not implemented and currently has no plans to implement Medicaid work requirements, provide the bases for this estimate. After coding the work requirements of Kentucky and Arkansas, and ranking each on a 1-5 scoring scale, 1 being least severe and 5 being the most, I use total enrollment data for Arkansas, Kentucky, and West Virginia, and I estimate the difference-in-differences of the percent of those enrolled divided by the state's annual population between West Virginia, my control state, and Arkansas, my treatment state. After standardizing and then comparing Arkansas to West Virginia through difference-in-difference testing, I find a net drop in enrollment with substantial uncertainty associated with it, leading to the conclusion in the first step of this analysis showing that while Arkansas has more of a decrease post-treatment in Medicaid enrollment than West Virginia, much of it is likely due to other factors.

These states' trends are similar enough to provide an effective comparison for Kentucky, however. I found that if Kentucky ever implements work requirements, the change due to work requirements alone will be a decrease in enrollment by 24,129 people, over and above the existing trend. The estimation of Kentucky with work requirements is based on the difference-in-differences estimation between Arkansas and West Virginia subtracted from Medicaid enrollment annual population in Kentucky from June 2018 to December of 2018. This analysis

provides an estimation of what could happen to total Medicaid enrollment in Kentucky, and possibly other states, if work and community engagement requirements are implemented. Future studies will hopefully have more data available in order to construct a more valid study of the actual effect of work requirements in states that have implemented them in comparison with those that have not and do not plan to – in order to inform the states that plan to what will happen to their Medicaid enrollment. Future studies that ask this same or a similar research question should also take into account other factors affecting Medicaid enrollment to provide a better basis for their estimation in order to predict their effect on the state(s) in question.

Introduction

The Patient Protection and Affordable Care Act (PPACA), colloquially known as Obamacare or the ACA, signed into law by President Obama in 2010, mandated that states could use federal funds to expand their Medicaid programs to include “adults up to 138 percent of the poverty level” (MACPAC, 2019). While this mandate was originally a requirement under the law, in *National Federation of Independent Business v. Sebelius*, the Supreme Court found this requirement unconstitutional in that Congress could not use its spending power in this way, making Medicaid expansion optional (MACPAC, 2019). Since this decision in June of 2012, states have followed different paths to coverage expansion, taking advantage of provisions in Section 1115 of the Social Security Act that allow for research and demonstration waivers. As of March 15, 2019, eight states applying for Medicaid expansion were granted approval for their Section 1115 waivers, and they include work requirements for beneficiaries. Further, six of the waivers out of the total of eighteen (across seventeen states) that were pending as of April 6, 2019 (and waiting to receive approval or rejection with comments from the Centers for Medicare & Medicaid Services (CMS)) were waivers with work requirements (Kaiser Family Foundation, 2019). Two of these states, Arkansas and Kentucky, were granted federal authority from CMS to implement “work and community engagement requirements” (MACPAC, 2018b). CMS also “issued subregulatory guidance” for states that decide to implement similar requirements in the future (MACPAC, 2018b).

A federal district court blocked Kentucky’s waiver for work requirements in June of 2018 stating that “at minimum, the Secretary [of the Department of Health and Human Services (HHS)] failed to ‘adequately analyze’ coverage” when approving Kentucky’s waiver. According to presiding Judge Boasberg, this failure to analyze impacts of work requirements left questions

concerning the potential loss of coverage among current Medicaid recipients and the promotion of Medicaid as a source of coverage for potential beneficiaries (Galewitz, 2018). After this court ruling, the waiver was edited and resubmitted, gaining approval from the Trump Administration, but not officially implemented (Yetter, 2019). Instead, Kentucky faced a court challenge. On March 27, 2019, the Federal District Court for the District of Columbia blocked both Kentucky's and Arkansas's work requirements in *Charles Gresham et al., v. Alex M. Azar II, et al.* (2019). In his decision, the judge cited parts of 5 U.S.C. § 706(2), the Administrative Procedure Act, and case precedent from *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513 (2009). On April 10, 2019, the Trump Administration appealed this decision to the U.S. Court of Appeals for the District of Columbia Circuit (Cheves, 2019). This new development will be expanded upon further, with the analysis in this paper exploring the possibility that this court ruling will be overturned, or that the waivers will eventually be approved after states make enough changes to their plans to satisfy a court (Goodnough, 2019).

While Medicaid work requirements are considered a fairly new policy option, they have been a central piece of the Trump Administration's health care policy platform since the inauguration. Kentucky and Arkansas, for example, both define work requirements as the following. If an individual who is eligible for Medicaid meets certain criteria and is not exempt from the program for certain allowable reasons, the individual must complete and report to their state's Medicaid office 80 hours of specific types of either "community engagement activities" or employment per month; failure to do so results in forfeiture of Medicaid benefits until such time the state allows the individual to re-apply to the program. The reasoning often cited to justify federal support for and state implementation of such programs is that work requirements encourage labor force participation and, therefore, economic growth. Supporters also state that

government provision of healthcare can be warranted or further supported when the contributions of an increasing number of Medicaid-eligible Americans, who are able to work, volunteer, or further their education begin doing so at an adequate rate (Sanger-Katz, 2018).

Others argue that these work requirements (and other methods in which the federal government has delegated power to the states regarding Medicaid) are enacted in lieu of failed efforts to repeal or stop the Medicaid expansion program provided to states through the ACA (Solomon, 2018). Still one more argument for these policies is that some of the able-bodied persons who are “taking advantage” of government insurance will go back to the private insurance market in the face of work requirements and the related administrative burden that must be overcome to complete them. The beneficiaries in this scenario may not want or be able to fully complete these administrative obstacles (Solomon, 2018).

Section 1115 of the Social Security Act allows for “demonstration projects” in which new and experimental policies can be proposed by states. In order to gain approval from the federal government, these policies must meet certain requirements, and must, according to Section 1115 guidelines, be “likely to assist in promoting the objectives of [Medicaid]” and “show that a proposed demonstration project will increase and strengthen coverage, increase health care access, improve health outcomes, or increase the efficiency and quality of care for Medicaid beneficiaries and other low-income populations” (Solomon, 2018). Before the Trump Administration took office, none of the states hoping to implement their own demonstration projects through Medicaid expansion could meet the requirement of proof necessary—that their project would increase or strengthen coverage, health outcomes, efficiency, or quality of care (Solomon, 2018). These proposals were then not approved by the Obama Administration, on the grounds that HHS found these policies “would have the effect of reducing enrollment” and “that

these policies did not advance Medicaid’s objectives” (Greenwald and Solomon, 2018). In Utah, Indiana, Kentucky, Maine, Wisconsin, Arkansas, and New Hampshire, the proposals delineated that “Medicaid eligibility” would be based on “work and work-related activities” and in Utah, Maine, and Wisconsin, time limits were even imposed on how long people could be enrolled in Medicaid (Solomon, 2018).

Under the Trump Administration however, CMS created new policy guidance and objectives, making different connections to the usefulness of work requirements and presenting new rationales for why they work. Administrative burden, a concept concisely defined by Moynihan, Herd, and Harvey as “an individual’s experience of policy implementation as onerous” plays a further role in the rationale behind these work requirements, as well as provides a framework for classifying certain aspects of these work requirements and will be used as such in this paper.

Many of the aforementioned states’ proposals were, at least initially, approved through these new administrative policies under CMS once the Trump Administration took office. Two of these states that received approval, Kentucky and Arkansas, are studied herein. The primary research question is: What effect did the administrative burden of Arkansas’s work and community engagement requirement program have on Medicaid enrollment and dropout rates, and how can this estimate the results of Kentucky’s Medicaid waiver and its own work requirements?

Literature Review and Hypothesis

Under the Trump Administration, states were invited to change Medicaid eligibility requirements and add work requirements (Englehard, 2018). Kentucky was the first state to alter

its Medicaid waivers in this manner and receive this approval. Arkansas, which received approval shortly after Kentucky, was the first state to implement them because Kentucky's work requirements were challenged in court. Currently, almost half of all states are either considering or actively pursuing approval for work requirements in Medicaid (Englehard, 2018).

The rationale that CMS uses to support the legality of work requirements in expansion proposals is, in summary, that there is a connection of employment to the aforementioned outcomes, and that these programs have increased overall employment, participation in job training, and general increase in earned income for those that leave the Medicaid program for "commercial coverage and self-sufficiency," thereby decreasing reliance on the government's public programs (MACPAC, 2018b). Further, in Section 1115 of the regulations for similar, future state expansion endeavors, CMS states that these requirements "promote upward mobility, greater independence, and improved quality of life among individuals" (MACPAC, 2018b). Those that oppose these proposals are concerned about the "potential harms to beneficiaries," and bring up the fact that many Medicaid beneficiaries are already working (MACPAC, 2018b).

These waiver programs are closely linked to the agenda of the Trump Administration. In March 2017, Human Services Secretary Tom Price and CMS administrator Seema Verma sent a letter to the governors of the United States informing them of the Trump Administration's views regarding the Affordable Care Act's Medicaid expansion proposal, calling it "a clear departure from the core, historical mission of the program" and stating that the rigid nature of the Medicaid expansion rules under the ACA, prior to the Trump Administration and its own vision for allowing states more freedom and options to expand, "provided states with an incentive to deprioritize the most vulnerable populations" (Price and Verma, 2017). This precedes the perceived purpose of the letter, which was to announce their support for methods such as work

requirements, stating “It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence” (Price and Verma, 2017).

In addition, in a speech to the National Association of Medicaid Directors (NAMD) 2017 Fall Conference, Administrator Verma again mentioned work requirements, emphasizing the Administration’s inclusion of them as a cornerstone of their Medicaid policy. She said, in part, “For people living with disabilities, CMS has long believed that meaningful work is essential to their economic self-sufficiency, self-esteem, wellbeing and improving their health. Why would we not believe that the same is true for working age, able-bodied Medicaid enrollees? Believing that community engagement requirements do not support or promote the objectives of Medicaid is a tragic example of the soft bigotry of low expectations consistently espoused by the prior administration. Those days are over” (Verma, 2017). This is a clear explanation of policy and demonstrates the Trump Administration’s reasoning for the support of work requirements for Medicaid.

CMS has approved the waivers requested by (among others) Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, and Wisconsin. Their waivers share certain similarities. For example, their waivers all “require certain non-disabled, non-elderly, non-pregnant individuals to meet work and community engagement requirements as a condition of Medicaid eligibility” (MACPAC, 2018b). Though they share this adopted policy, the states differ in their implementation of it by setting different standards for the work requirements. These differences are found in the groups that are required to participate in these work programs to be eligible for Medicaid and which individuals within those groups are exempt, in the activities that fulfill the

work requirements, the required number of hours that must be completed, and in the severity of the penalties associated with not complying with the requirements (MACPAC, 2018b).

To allow for this flexibility in program administration, CMS provided few guidelines, most of which are quite vague. For example, one guideline is that “states must automatically consider individuals in compliance with Medicaid requirements if they are satisfying TANF or SNAP work requirements” as well as the encouragement of “states to consider allowing a range of activities to qualify as community engagement, including career planning, volunteering, and participating in tribal employment programs” (MACPAC, 2018b).

Arkansas received approval from the federal government and began implementation of its work requirement waiver in June 2018 (Wilson and Thompson, 2018). Monthly enrollment and other data have been collected since June by the Arkansas Department of Human Services (Arkansas Department of Human Services, 2019). A preliminary analysis by the Kaiser Family Foundation found, in part, that a “total of 18,164 individuals have lost coverage since September 2018, due to failing to meet the work and reporting requirements” and also, “78% of those not exempt (4,776 out of 6,087) did not report 80 hours of qualifying work activities” (Rudowitz et al., 2019). All data are publicly available; however, Arkansas is the only state of the three with recorded, actual data at this time. Indiana and New Hampshire have only provided projected outcomes data.

Kentucky’s work requirement waiver, entitled “Kentucky Helping to Engage and Achieve Long Term Health” or KY-HEALTH, as previously noted, received approval from the Trump Administration, a decision that was later struck down by a federal court decision in *Stewart v. Azar*. The main argument in *Stewart v. Azar* was that the approval of the waiver seemed arbitrary and in violation of the Administrative Procedure Act (APA) and did not take

into account its impact on the health coverage of those eligible for Medicaid (Musumeci, 2018). After minor edits were made to the waiver, the administration approved it a second time (Yetter, 2019). This most recent version of the waiver is used for the analysis in this paper. Also, as noted in the introduction, it has been challenged again in court, and a decision was handed down on March 27, 2019 in *Charles Gresham, et al v. Alex M. Azar et al.* In the ruling, the same Judge Boasberg once again blocked Kentucky's work requirements as well as Arkansas's. He first examined Arkansas's original approval by HHS Secretary Azar and found it to be "arbitrary and capricious" and that Azar failed to "consider adequately" the impact, in the same manner as Kentucky when he blocked their requirements the first time (Goodnough, 2019). Then, once again, Kentucky's work requirements were blocked based on Judge Boasberg's view that the changes were so minimal that the new plan "has essentially the same features as it did before" and that HHS did not consider to the fullest extent "the coverage-loss consequences" (Goodnough, 2019).

The concept of administrative burden, as briefly noted above, is further explained by Moynihan, Herd, and Harvey as what shapes citizens' experience of the interactions they have with their government, including whether they can successfully access services provided to them by the government as well as be treated fairly and respectfully (Moynihan et. al, 2015). Further, it "alters the unit of analysis in citizen-state interactions" and the degree of severity of such burdens corresponds to how much this unit of analysis in these interactions is altered (Moynihan et. al, 2015). This directly affects the subject matter of state-imposed Medicaid work requirements as well as many other government services and their provision.

Lavertu, Lewis, and Moynihan also discussed the concept and theory of administrative burden in government, particularly how it was coupled with the administration of George W.

Bush's Program Assessment Rating Tool (PART) (Lavertu et al., 2013). Although the subjects were government employees instead of the Medicaid population, they were the ones affected by the government administrative burden in this scenario, in having to follow the new government requirements to assess their own programs in whatever ways the Office of Management and Budget, that managed the Bush Administration's PART system, asked of them. Further, Lavertu, Lewis, and Moynihan found that the managers surveyed in "agencies associated with liberal programs and employees ("liberal agencies") agreed to a greater extent than those in agencies associated with conservative programs and employees ("conservative agencies") that PART required significant agency time and effort and that it imposed a burden on management resources" (Lavertu et al., 2013). They focused on "Clinton and Lewis's measure of agency ideology" in order to define which agencies were "liberal" versus those that were "conservative," which essentially was based on survey data collected by those in academia, think tanks, and media outlets that deal with the federal government. They also combined this with "the percentage of agency career managers that self-identified as Democrats (including independents who lean Democratic); the average respondent ideology (reported on a seven-point scale from "very conservative" to "very liberal"); and the average respondent ideal point based on how respondents themselves would have voted on bills in Congress" (Lavertu et al., 2013).

It is also important to note that Lavertu et al. found objective differences between federal agencies when it came to quantity and severity of burdens that PART imposed. They found that "liberal agencies were required to evaluate more programs and implement more improvement plans relative to their organizational capacity" (Lavertu et al., 2013). This further supports the idea of political motivation behind the costs imposed as administrative burden at many junctures within the government.

Heinrich (2018) studied the effect of immigration policy in the United States, and how administrative burden occurs, in part, in the form of the unclear law resulting from “compromises and tradeoffs” at the federal level that leave a large part of implementation and enforcement of these laws and policies up to state and local governments’ discretion. Specifically, she studied a policy in Texas that denied some children born to Mexican immigrants, who were citizens, access to their birth certificates, and interviewed parents and analyzed survey data of children affected by this policy (Heinrich, 2018). The purpose of this was to show what outcomes from her study could also apply to other policies related to immigration that hinder immigrants’ access to government assistance and benefits and ultimately “impose barriers to their integration into society” through this administrative burden (Heinrich, 2018). She found “serious, adverse consequences” for these children, reiterating that this was largely due to the administrative burden imposed in the enforcement and the lack of transparency and fairness of the laws at the state and local levels (Heinrich, 2018). She concludes by calling on those in the fields of public administration and political science to further study administrative burden, and points out that her findings are just one example of how discretion during the implementation process “can diminish the transparent and effective execution” of such policies, “as well as our commitment to equality of opportunity under the law” (Heinrich, 2018).

Finally, Moynihan, Herd, and Ribgy, in their 2013 analysis of the administrative burden of Medicaid procedures in all 50 states, present the most comprehensive model, providing a useful context for this analysis. They studied several aspects of each of the Medicaid applications and procedures for all states, and found that in states with Medicaid applications that had fewer questions, required lower expense reporting burden, and did not require an interview, the rates of take-up for Medicaid were higher (Moynihan et al., 2013). In addition, they concluded by

revealing a political aspect of administrative burden: in states where Democrats were in power, applicants were less likely to face a high administrative burden (Moynihan et al., 2013). The authors conclude by stressing the importance of future studies of administrative burden using the type of measures they used. They note that studies largely examine legislation but rarely administrative rules that are also a form of policy, and often, burden (Moynihan et al., 2013).

Therefore, regarding the many current Medicaid recipients and their struggle with maintaining benefits when work or community engagement requirements are put in place, these programs are likely to impose an administrative burden on these recipients. Moynihan, Herd, and Harvey add to the theory of administrative burden by delineating three distinct types: learning costs, psychological costs, and compliance costs (Moynihan et al., 2015). Learning costs “arise from engaging in search processes to collect information about public services, and assessing how they are relevant to the individual” (Moynihan et al., 2015). Psychological costs “include the stigma of applying for or participating in a program with negative perceptions, a sense of loss of power or autonomy in interactions with the state, or the stresses of dealing with administrative processes” (Moynihan et al., 2015). Compliance costs “are the burdens of following administrative rules and requirements” which could be “costs of completing forms, or providing documentation of status” or in the business world, the many costs associated with compliance with government regulations (Moynihan et al., 2015). This is the main theoretical lens through which I conduct my research, and that I use for my classification and comparison of the work requirements in both Arkansas and Kentucky.

This literature leads to the aim of this paper, which will be to examine the effects of Medicaid work requirement implementation and its associated administrative burdens on enrollment in Arkansas’s federally approved expansion program. In a second step, I will be able

to estimate the impact the administration of work requirements in Kentucky would have, for all aspects of the program this state shares with Arkansas. Arkansas was chosen because it was the first state to implement these work requirements and at present the only state with data after implementation available to the public. Based on the literature reviewed, my hypothesis is that with a greater administrative burden, more eligible people will forgo a benefit, and, more specifically, in this case, more people that are eligible for Medicaid will forgo Medicaid due to the administrative burdens associated with work requirements. Arkansas's trend is expected to be similar in Kentucky once it implements its own work requirements, especially if the two states have a similar amount and level of severity of these burdens within the proposals for their work requirements in each of their waivers.

Research Design

To begin, it is important to contextualize both Arkansas and Kentucky and the similarities that led them to impose these work requirements in the first place. Therefore, I briefly address any similarities between the two states' governments' structure and the political parties in power in the governorship, house, and senate at the time that they submitted these waivers. This will give initial insight to and lay important groundwork for the rest of the research of this paper.

This information will also help strengthen the internal validity of the study, as comparing two different states on an issue such as this can prove to be problematic if the proper factors are not taken into consideration and controlled for. The similarities between the two work requirement waivers in Arkansas and Kentucky are the basis of this analysis, but to examine whether there was a decrease in enrollment in Arkansas that can be attributed to the work requirements, I will use West Virginia as the control case for Arkansas. The two states are

regionally close, and upon initial viewing of the enrollment trend, West Virginia follows a broadly similar trajectory as pre-treatment Arkansas. West Virginia has not pursued work requirements at this time.

Total enrollment data for Arkansas, Kentucky, and West Virginia can be found via Medicaid.gov, and specifically, the page entitled “Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data” (Medicaid.gov, 2019). This raw data can be downloaded and is available for public use. This data will be used to show the trends of Arkansas, Kentucky, and West Virginia’s total Medicaid enrollment for the months before and after June 2018, or, the month in which Arkansas began implementation of their work requirements.

I will estimate the effect of this policy change by looking at the difference between the change in enrollment in Arkansas and the change in enrollment in West Virginia, over the same time period (encompassing the policy change in Arkansas, but not West Virginia). I will then use the difference of change in enrollment for both of these states as an estimate of the effect of the work requirements on Arkansas’s Medicaid enrollment, net of other trends. This estimate will in turn serve to estimate enrollment changes in Kentucky if the work requirements are approved. Figure 1 shows each state’s Medicaid enrollment over time, and Figure 2 shows enrollment as a percentage of each state’s population, to allow for comparability.

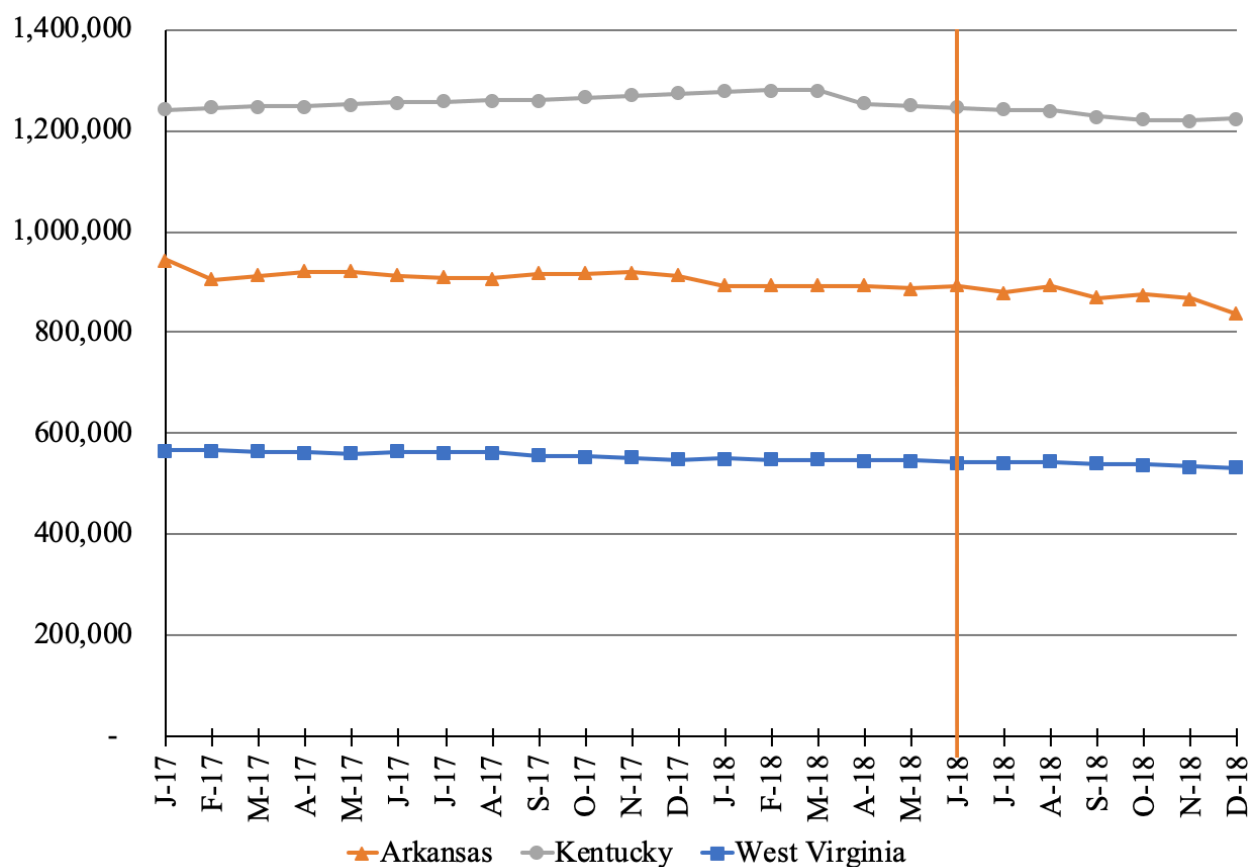
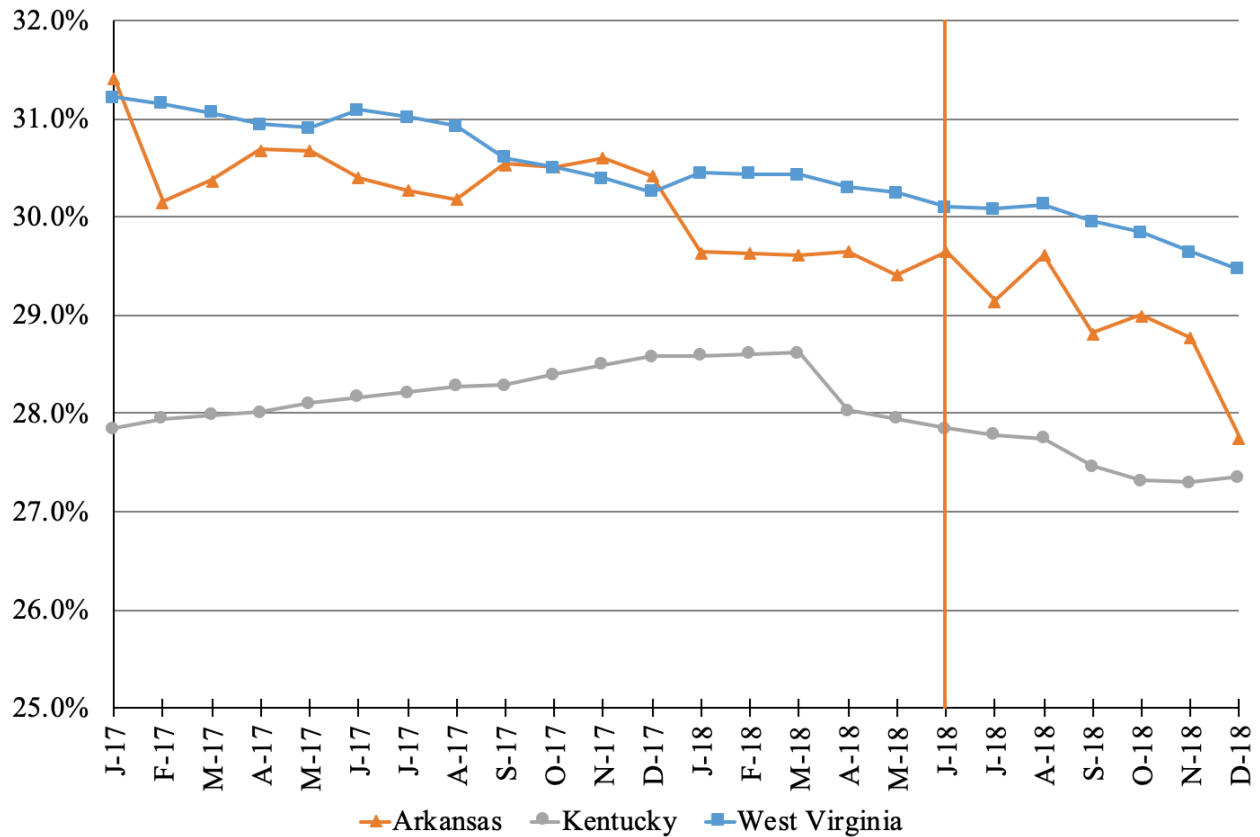
Figure 1: Total Medicaid Enrollment in Arkansas, Kentucky, and West Virginia

Figure 2: Percent of Medicaid Enrollees in Each State Based on Yearly Population in Arkansas, Kentucky, and West Virginia



The changes in the trend lines in Figure 2 look more dramatic than those of Figure 1, and this is due to the changes in population.¹ Also, it is important to note that each month out of the year uses the same population, the census annual estimate. Therefore, there is a change in population only from December 2017 to January 2018, in which Arkansas's estimate increased by 10,828 and West Virginia's estimate actually decreased by 11,216.

¹ In this same vein, it could also be important to compare the slopes of these trends. The slope (or the average month-to-month change) of the pre-treatment trend for Arkansas is $(-0.020)/17 \text{ months} = -0.001$, or -0.1%. The slope of the post-treatment trend for Arkansas is $(-0.019)/7 \text{ months} = -0.003$, or -0.3%. The slope of the pre-treatment trend for West Virginia is $0.010/17 \text{ months} = -0.0006$, or -0.06%. The slope of the post-treatment trend for West Virginia is $(-0.006)/7 = -0.0008$, or -0.08%.

Moynihan, Herd, and Ribgy created their own method to code the administrative burden of Medicaid procedures in all 50 states, which included looking at the application for Medicaid, and also the enrollment process overall in 2013. These coding categories included: length of application (“How long (measured in number of words) is the state Medicaid application?”), number of questions on the application, the income reporting burden (“Do individuals have to report income sources in the application process? Do they have to document income sources? How many different types of income have to be specified?”), the expense reporting burden (“Do individuals have to report expenses in the application process? Do they have to document expenses? How many different types of expenses have to be specified?”), whether or not individuals have to provide documentation proving their residency in the state, whether or not the enrollment process requires “an in-person interview to qualify for the program,” and whether or not an applicant has “to renew their status every 6 months as opposed to every year” (Moynihan et al., 2013). They then compared this (now quantitative) data on the burden scores using a series of OLS regressions “on measures of state economic/fiscal and political context” (Moynihan et al., 2013).

This analysis draws on some of the same concepts used by Moynihan, Herd, and Ribgy for coding the administrative burden imposed on Medicaid recipients in Arkansas and Kentucky. I will analyze both waivers and sort data into the following categories: age requirement, hour requirement for work or community service activities in order to remain eligible for Medicaid benefits, the standard(s) for being above and below the federal poverty line and still receiving Medicaid benefits, the reporting methods allowed or provided, reasons for disenrollment, the types of activities that are allowed to complete the requirement, the ways in which people are allowed to reapply after loss of eligibility (if any), premium or copayment or cost-sharing

specifications and requirements, whether or not the state will still provide non-emergency medical transportation, and all of the exemptions for these aforementioned requirements or burdens. This can be found in more detail in the Analysis and Findings section.

These are compared side by side and each state's requirements are included in the analysis for comparison. I hypothesize that enough of these categories of administrative burden are similar enough to show that Kentucky's total enrollment will follow a similar trajectory in Medicaid enrollment as Arkansas over time. Therefore, monthly Medicaid enrollment in each state is the primary unit of analysis in this paper. The data are then analyzed to see if there is an overall shift leading to a decrease, using a difference-in-differences estimator.

Following this analysis, the goal is to be able to provide data that could give a sense of the future effect that work and community engagement requirements could have on the state of Kentucky once they are implemented, and whether it will follow a similar trend.

Background

The structures of the state governments of Arkansas and Kentucky are quite similar, especially in recent years. In both states, the Republican party has control of the governorship as well as both houses of the state legislature, or what is commonly called a "trifecta." Arkansas's current Republican governor, Asa Hutchinson, has been governor since he was elected in 2015 and was preceded by a Democrat, Mike Beebe. A Republican majority has controlled both the Arkansas House of Representatives and state Senate since 2012, and the number of Republican representatives has grown after each election since 2012 as well. In Kentucky, Republican Governor Matt Bevin has been governor since 2015. He was preceded by Steve Beshear, a Democrat. A Republican majority has controlled the state Senate since 2014, but the House of

Representatives has only had a Republican majority since 2016. That is to say, Kentucky's "trifecta" has only been in effect since 2016. A Republican trifecta also currently exists in West Virginia; however, this has not been the case for long. The current governor, Jim Justice, was elected and assumed office as a Democrat, but shortly after announced that he was switching to the Republican Party, and now holds office as a Republican governor. The West Virginia legislature consists of the West Virginia House of Delegates and the West Virginia Senate. Both the house and senate have been under Republican control since 2014.

Analysis and Findings

I began my data collection by finding both states' CMS-approved Section 1115 waivers and reading through each of them. As I read through them, any requirement or exemption listed was copied and pasted into a document of my own in order to keep track of all of them. Each requirement and exemption was then compared side by side to its counterpart in the other state and those that were similar, or exactly the same, were identified as such. Then, those that clearly would impose some sort of burden; psychological costs, compliance costs, or learning costs on Medicaid recipients were selected and eventually included in the table viewable in the Appendix. This table includes the relevant work requirements and exemptions coded directly from both Arkansas and Kentucky's 1115 waivers. This analysis did draw on the coding categories for administrative burden by Moynihan, Herd, and Ribgy (2013), and additional categories: Exemptions (for Work Requirements in General), General Reporting Requirements, and Requirement of Hours to Remain Eligible.

I also included in the table my own 1-5 scoring scale, 1 being least severe and 5 being the most, as to what I considered to be the severity of burden for each requirement and exemption in

both Arkansas and Kentucky's 1115 waivers explaining their work requirement plans. I included the exemptions to these rules that each state listed as well, in order to give a fuller picture of the burden that is or will be imposed on citizens. It is important to note that I rated exemptions that seemed less stringent (in other words, that they exempt more people and more groups) consistently lower on the same scoring scale because I view a higher amount of people exempted as a lower burden on the state's Medicaid eligible population as a whole. Below is a simplified version of overall scores. A more detailed version of this table in the Appendix, and includes the scores for each category, total scores, and total possible score for each of the states' waivers.

Requirement/Exemptions	Kentucky HEALTH Score	Arkansas Works Score
Age Requirement	3	3
Federal Poverty Line (FPL) Standard	4	4
Exemptions (for Work Requirements in General)	3	2
General Reporting Requirements	2	4
Requirement of Hours to Remain Eligible	4	4
Types of Allowed Activities to Complete Requirement	3	2
How to Retry/Reenter/ Reapply After Loss of Eligibility	2	5
Premium/Copayment	4	4
Premium/copayment exemptions	3	2
Waiver of the Requirement to Provide Non-Emergency Medical Transportation (NEMT)	3	1
Reasons for Disenrollment	4	2
Retroactive Eligibility	2	3
TOTAL SCORES:	37	36
TOTAL POSSIBLE POINTS:	60	60

Kentucky's administrative burden, according to my scoring mechanism, scored an almost negligible one point higher than Arkansas, and therefore I think we can expect similar results in a likely drop in enrollment as the Arkansas decrease and therefore, the estimate for Kentucky should be quite similar to the one done in this analysis. This one point is a difference and will be

taken into account in my analysis, but it is not practically significant, as Arkansas's score is 97.3% of Kentucky's, and could be the result of error when assigning scores based on the severity of the requirements and the amount of burden they imply. These categories of administrative burden are similar between the two states and show that Kentucky's total enrollment will likely follow a similar trajectory as Arkansas's in Medicaid enrollment over time. Arkansas can then be used as a basis for making a projection for Kentucky. It is important to note that it is possible that some burdens are more important than others, and this could affect the analysis. If the difference is greater in one of the more "important" categories, or in other words, a category that is more likely than others to lead a Medicaid recipient to lose or withdraw from coverage, this could mean that there is a larger difference overall between the two states' Medicaid work requirements, and therefore a study in which the two states' enrollment would be less comparable when explaining a trend in Medicaid enrollment.

Scoring is in relation to the other state's requirements. For example, in the "Reasons for Disenrollment" category, Kentucky's waiver listed the following: Failure to make required premium contributions within sixty (60) days of the date of invoice, failure to provide the necessary information for the state to complete an annual redetermination, and failure to timely and accurately report a change in circumstance affecting eligibility only in such circumstances where a beneficiary would no longer be eligible for Medicaid. Arkansas listed the following: Determined to be medically frail after they were previously determined eligible and failure to report compliance for 3 months (state will dis-enroll the beneficiary for the remainder of the calendar year). I rated Kentucky a 4 and Arkansas a 2 on this category for three reasons. First, Kentucky offers less of a grace period for their premiums that Arkansas offers for their compliance reporting (60 versus 90 days). Also, the vague language presents a burden in and of

itself; “timely and accurately” should definitely be more specific – especially since it is regarding reasons for total disenrollment from the program and benefits. Finally, Arkansas includes “determined to be medically frail” after already determined eligible, whereas Kentucky chooses to use the phrasing “change in circumstance affecting eligibility only in such circumstances where a beneficiary would no longer be eligible for Medicaid.” This encompasses medical frailty – and many other possible changes. Therefore, Kentucky’s administrative burden is deemed to be this much higher than Arkansas’s regarding this category.

An example of coding exemptions rather than requirements is in the category “Premium/copayment exemptions.”

Kentucky included the following groups as exempt:

- Pregnant women
- Survivors of domestic violence
- Former foster care youth
- Beneficiaries who are eligible for transitional medical assistance as described in sections 1925 and 193 I (cX2) of the Act
- Those determined medically frail

Arkansas, on the other hand, included the following:

- Individuals ages 1 and older and under age 18 and infants under age 1 whose income is under 150 percent FPL (for premiums) or 133 percent FPL (for cost sharing)
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age
- At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter
- Disabled children, except as provided at § 447.55(a)(4) (premiums), who are receiving medical assistance by virtue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act
- Pregnant women, except for premiums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-related, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends

- Any individual whose medical assistance for services furnished in an institution, or at state option in a home and community-based setting, is reduced by amounts reflecting available income other than required for personal needs
- An individual receiving hospice care, as defined in section 1905(o) of the Act
- An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all cost sharing
- Individuals who are receiving Medicaid because of the state's election to extend coverage as authorized by § 435.213 of this chapter (Breast and Cervical Cancer).

While there are a larger number of groups in Arkansas, I viewed many of these groups as being accounted for in Kentucky as well in more general terms. However, there were also several that were not, so it was largely due to the fact that Arkansas exempts more groups that I rated Kentucky a 3 and Arkansas a 2. The number is lower here, again, because more exemptions surely mean a lower burden as more people do not have to provide work or community engagement hours in order to receive Medicaid. This method may not work as well in a future study if it were to compare all fifty states, and would probably benefit from using more objective methodology such as Moynihan et al.'s, described previously.

I collected, cleaned, and sorted total enrollment data for Arkansas, Kentucky, and West Virginia, found via Medicaid.gov, “Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data” (Medicaid.gov). To determine the previous trend of enrollment before June 2018 (to reiterate – the month of the beginning of implementation of Arkansas’s work requirements), I collected data for Arkansas, Kentucky, and West Virginia starting in January 2017. The analysis starts here, and not earlier, for two reasons: enrollment is not on a consistent trend before 2017, and in January 2017 the Trump Administration took office, which changed the political environment. This data ends in December 2018, as this is the most recent month that data could be found for all three states.

Using this monthly enrollment data, I standardized by calculating the change in enrollment from month to month in all three states. Using this data, I estimated the difference-in-differences of the percent of those enrolled divided by the state's annual population between West Virginia, my control state, and Arkansas, my treatment state. Below are my findings:

Table 1: Difference-in-Differences Estimation of Percentage of Medicaid Enrollment Per State Annual Population

	Average Pre-June 2018 Medicaid Enrollment	Standard Error	Average Post-June 2018 Medicaid Enrollment	Standard Error	Difference between Pre- and Post-June 2018 Average Enrollment	Standard Error
Arkansas	30.21%	0.12%	28.85%	0.25%	-1.36%	0.26%
West Virginia	30.67%	0.09%	29.85%	0.12%	-0.81%	0.16%
Difference between Arkansas and West Virginia	0.45%	0.15%	1.00%	0.27%	-0.54%	0.30%

In Table 1, 30.21%, 28.85%, 30.67%, and 29.85% represent the proportions of average Medicaid populations over the respective months for their respective states. In other words, each of these is the average of each month's total Medicaid enrollment divided by the total population for that year. -1.36% is the difference in enrollment between the average pre- and post-June 2018 Medicaid enrollment in Arkansas, meaning that there is a decrease of 1.36 percent on average of total Medicaid enrollment in Arkansas between the two periods. -0.81% is the difference in enrollment between the average pre- and post-June 2018 change in Medicaid enrollment in West Virginia, meaning that there is a decrease of 0.81 percent on average of total Medicaid enrollment in West Virginia between the two periods. The difference between Arkansas and

West Virginia shows that there is a slightly larger decrease on average in Arkansas in relation to West Virginia: about 0.54 percent.

The decrease in total enrollment between the pre-treatment period (12 months of 2017 and 6 months of 2018, so 2/3 of the time is in 2017 and 1/3 in 2018) and post-treatment period (6 months of 2018) can be calculated by multiplying 30.21% by 2/3 of 3,002,997 times 1/3 of 3,013,825, and subtract from this figure 28.85% multiplied by 3,013,825.² The value of this calculation is 41,931. This is the gross drop in enrollment, and to find the percentage of this that was due to work requirements, 54 (from 0.54 percent) divided by 136 (from -1.36 percent), or 0.397. Just under 40% lost enrollment due to the work requirements according to this analysis, or 16,649 people. This can be visualized using Figure 2.

This estimation is different than the actual drop in enrollment according to the percentage change in population, which is a decrease of 49,937, as opposed to the estimation of 41,931. This figure multiplied that same percentage, 0.397, is 19,828 as opposed to the estimation of 16,649. This many people were disenrolled due to work requirements. The difference between these two numbers shows that there is some distortion introduced by my analysis, but I had to standardize to compare two states with different population sizes. This can be visualized in Figure 1.

West Virginia did not have a treatment (implementation of a Medicaid work requirement program) during the entire period of study and Arkansas did, during the months studied of June 2018 to December 2018. Therefore, this first step of this analysis shows that while Arkansas has more of a decrease post treatment in Medicaid enrollment than West Virginia, it is likely due to other factors. It is also important to acknowledge that the key assumption of parallel trends is not

² The equation described above is: $0.3021 * (((2/3) * 3,002,997) + ((1/3) * 3,013,825))) - ((0.2885) * 3,013,825)$

truly accurate for the pre-treatment time period, or, in other words, these trends are not truly parallel.

Having estimated the decrease in enrollment as a result of work requirements net of existing trends in Arkansas, I am now applying this to Kentucky's enrollment numbers in order to estimate how many fewer people will be disenrolled if and when Kentucky implements their work requirements.

In Table 2 below, 27.54% is the average percentage of those enrolled in Medicaid per the total annual population in Kentucky from July 2018 to December 2018, or the same time period as the entire post-treatment period for Arkansas. It is important to note again that Kentucky has not implemented its work requirements yet, and therefore did not during this time. 27% represents the estimated percentage of those enrolled in Medicaid per the total annual population in Kentucky if work requirements were to be implemented.

In other words, this shows that if Kentucky ever implements work requirements, the change due to work requirements alone will only be about a 0.54 of a percent decrease, the same as the estimated effect in Arkansas. Multiplying 27.54% by the estimated population in 2018 in Kentucky, 4,468,402, and then subtracting 0.54% from 27.54%, multiplying this by the population, and subtracting the first number from the second, the number of enrollees that would be disenrolled during this period in Kentucky due to the administrative burden of work requirements is about 24,129 people, over and above the existing trend.³

This estimation of Kentucky with work requirements is based on the difference-in-differences estimation between Arkansas and West Virginia subtracted from the change in

³ The equation described above is $(0.275 * 4,468,402) - ((0.275 - 0.0054) * 4,468,402)$

average Medicaid enrollment of the total annual population in Kentucky from June 2018 to December 2018.

Table 2: Estimation of Percentage of Medicaid Enrollees for Kentucky Based on June 2018 to December 2018 Data

Estimation of Kentucky With Work Requirements (Post-Implementation)	27.00%	1,206,469
Kentucky With No Work Requirements	27.54%	1,230,598
Difference	-0.54%	-24,129

These findings are congruent to an extent with other similar studies that have already been done on enrollment declines in Arkansas. For example, an NPR report in February indicated that of the 62,000 recipients subject to the work requirements upon implementation, 18,000 had been disenrolled by December 2018 (Froelich, 2019). My estimate in Arkansas is about 16,245 disenrolled due to work requirements by December 2018. The NPR study did not use West Virginia as a control state so that could be one reason our numbers do not entirely agree. However, both my analysis and the NPR study agree to an extent that Medicaid enrollment has been declining in Arkansas, and the findings of my study stop short at being able to confidently say that the work requirements are responsible for this decline in enrollment.

Limitations

Limitations to this analysis include, first and foremost, the fact that, in studying West Virginia and Arkansas, I was analyzing two states that were already decreasing in enrollment before the work requirements in Arkansas even came into being. The ideal study would have a

flat, or even increasing, and more importantly, parallel, trend between the two states before the treatment in order to truly assess work requirements as the causal factor in this decrease in enrollment. However, in this study there is no way to tell for certain how much of that decrease is due to the administrative burden of work requirements.

Another limitation is external validity. The focus on the similar aspects of the two waivers will at least provide some external validity for applicability not only to Kentucky, but other similar states that receive approval for implementation of work requirements, but there are still many reasons why this analysis would not translate externally to other states if more Medicaid work requirements go forward and are implemented. Also, West Virginia is an imperfect control state but the use of a control state was important to the internal validity of this analysis. Internal validity also is a concern, however, because the demographic makeup is not taken into account for either state, including things like the age, race, and sex of the Medicaid enrollees studied. Hopefully, this research on recent occurrences and data will push forward healthcare policy research in this field, and provide an objective analysis of what happens when these work requirements are implemented, and considered when choosing to implement such policies in the future.

In addition, the post-treatment period for Arkansas's implementation was not as sufficient as I would have hoped, in order to have an analysis with more data points to show a more compelling picture of what the trend post-treatment would be. Future studies on this topic should and probably will have more post-treatment data to work with, again, if more work requirements for Medicaid are legally allowed to be implemented in the future.

Conclusion

In conclusion, this analysis provides an estimation of what could happen to total Medicaid enrollment in Kentucky and possibly other states if work and community engagement requirements are implemented. Using Arkansas's trend of decreasing enrollment numbers since they implemented their work requirements, I found an almost negligible net effect of work requirements alone on Medicaid enrollment in Arkansas, and estimated and predicted the same in Kentucky. Future studies on this subject matter will hopefully have more data available in order to construct a more valid study of the actual effect of work requirements in states that have implemented them in comparison with those that have not and do not plan to – in order to inform the states that plan to what will happen to their Medicaid enrollment. Future studies that ask this same or a similar research question should also take into account other factors affecting Medicaid enrollment to provide a better basis for their estimation in order to predict their effect on the state(s) in question, and explain the effect of other factors leading to disenrollment. While this issue is politically charged, future studies should focus on analyzing the objective results of these programs in order to inform policy on both sides of the aisle.

Appendix

Requirement/ Exemptions	Kentucky HEALTH	Score	Arkansas Works	Score
Age Requirement	Adult beneficiaries ages 19 through 64	3	Adults beneficiaries ages 19 through 64	3
Federal Poverty Line (FPL) Standard	Adults up to and including 133 percent of the FPL who meet the other criteria specified	4	Adults up to and including 133 percent of the FPL who meet the criteria specified	4
Exemptions (for Work Requirements in General)	<ul style="list-style-type: none"> • Former foster care youth • Pregnant women • Survivors of domestic violence • Primary caregivers of a dependent (limited to one caregiver per household) • Beneficiaries considered medically frail • Beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements • Full time students 	3	<ul style="list-style-type: none"> • Beneficiaries identified as medically frail⁴ • Those who are pregnant or 60 days post-partum • Full time students • Beneficiary is exempt from Supplemental Nutrition Assistance Program (SNAP) community engagement requirements • Beneficiary is exempt from Transitional Employment Assistance (TEA) Cash Assistance community engagement requirements • Beneficiary receives TEA Cash Assistance • Beneficiary is incapacitated in the 	2

⁴ What it means to be “medically frail” is not clearly defined in either state waiver, but I use for the working definition for both states the definition in Kentucky’s FAQ on their website about their work requirement waiver: Beneficiaries may be considered medically frail for many different reasons. Some of those reasons include: Disabling mental health diagnosis, chronic substance use disorder, serious and complex medical condition, significant impairment in ability to perform activities of daily living, diagnosed with HIV/AIDs, eligible for Social Security Disability Insurance (SSDI), chronic homelessness, or a survivor of domestic violence
<https://kentuckyhealth.ky.gov/Pages/FAQ.aspx/>

			<p>short-term, medically certified as physically or mentally unfit for employment, or has an acute medical condition validated by a medical professional that would prevent him or her from complying with the requirements</p> <ul style="list-style-type: none"> • Beneficiary is caring for an incapacitated person • Beneficiary lives in a home with his or her minor dependent child age 17 or younger • Beneficiary is receiving unemployment benefits • Beneficiary is currently participating in a treatment program for alcoholism or drug addiction 	
General Reporting Requirements	Monthly; methods allowed not listed	2	Monthly; allows beneficiaries to report monthly their community engagement qualifying activities or exemptions using ONLY an online portal	4
Requirement of Hours to Remain Eligible	Non-exempt beneficiaries must complete and report 80 hours per month	4	Must complete at least 80 hours per calendar month of one, or any combination, of the qualifying activities	4
Types of Allowed Activities to Complete Requirement	<ul style="list-style-type: none"> • Employment • Education • Job skills training • Job search activities • Community service 	3	<ul style="list-style-type: none"> • Employment • Education • Community service • Self-employment, or having an income that is consistent with being employed or self-employed at least 80 hours per month 	2

			<ul style="list-style-type: none"> • Enrollment in an educational program, including high school, higher education, or GED classes • Participation in on-the-job training • Participation in vocational training • Participation in independent job search (up to 40 hours per month) • Participation in job search training (up to 40 hours per month) • Participation in a class on health insurance using the health system, or healthy living (up to 20 hours per year) • Participation in activities or programs available through the Arkansas Department of Workforce Services, • Participation in and compliance with SNAP/Transitional Employment Assistance (TEA) employment initiative programs 	
How to Retry/Reenter/Reapply After Loss of Eligibility	<p>Able to reactivate eligibility on the first day of the month after completing 80 hours of community engagement in a 30-day period or a state-approved health literacy or financial literacy course [...] The option to take a course to re-enter from suspension is available one time per 12-month benefit period.</p>	2	<p>If the beneficiaries are noncompliant with the community engagement requirements or reporting requirements for any three months, eligibility will be terminated until the next plan year, when they must file a new application to receive an eligibility determination. At this time, previous noncompliance</p>	5

			with the community engagement requirement will not be factored into the state's determination of their eligibility	
Premium/ Copayment	<p>Premium of not less than one dollar per month and not to exceed 4 percent of household income</p> <p>a. Individuals with income above 100 percent of the FPL who are required to pay premiums and who do not make an initial premium payment will not be enrolled in Kentucky HEALTH and will be required to reapply should they wish to participate.</p> <p>b. Individuals at or below 100 percent of the FPL who are required to pay premiums and who do not make an initial premium payment will be enrolled in Kentucky HEALTH effective the first day of the month in which the sixty (60) day payment period expired; however, once enrolled, these beneficiaries will be subject to the requirements and conditions if the general requirements</p>	4	<p>Monthly premiums from beneficiaries with incomes above 100 and up to and including 133 percent of the federal poverty level (FPL)</p> <p>Beneficiaries above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.</p>	4
Premium/ copayment exemptions	<ul style="list-style-type: none"> • Pregnant women • Survivors of domestic violence • Former foster care youth • Beneficiaries who are eligible for transitional medical assistance as 	3	<p>Exemptions from cost-sharing set forth in 42 CFR Section 447.56(a):</p> <ul style="list-style-type: none"> • Individuals ages 1 and older and under age 18 and infants under age 1 whose income is under 	2

	<p>described in sections 1925 and 193 I (cX2) of the Act</p> <ul style="list-style-type: none"> • Those determined medically frail 		<p>150 percent FPL (for premiums) or 133 percent FPL (for cost sharing)</p> <ul style="list-style-type: none"> • Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age • At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter • Disabled children, except as provided at § 447.55(a)(4) (premiums), who are receiving medical assistance by virtue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act • Pregnant women, except for premiums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-related, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period 	
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			<p>following termination of pregnancy ends</p> <ul style="list-style-type: none"> • Any individual whose medical assistance for services furnished in an institution, or at state option in a home and community-based setting, is reduced by amounts reflecting available income other than required for personal needs • An individual receiving hospice care, as defined in section 1905(o) of the Act • An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all cost sharing • Individuals who are receiving Medicaid because of the state's election to extend coverage as authorized by § 435.213 of this chapter (Breast and Cervical Cancer). 	
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<p>Waiver of the Requirement to Provide Non-Emergency Medical Transportation (NEMT)</p>	<p>State does waive this requirement as applicable to them. They do not have to provide non-emergency medical transportation (NEMT) for beneficiaries enrolled in the new adult group, with exceptions for beneficiaries who are:</p> <ul style="list-style-type: none"> • Medically frail • 19- or 20-year-old beneficiaries entitled to Early and Periodic Screening or Diagnostic, and Treatment (EPSDT) services • Former foster care youth • Survivors of domestic violence • Pregnant women 	3	<p>State does not waive requirement – non-emergency medical transport services will be provided through the State’s fee-for-service Medicaid program – and prior authorization will be established for the beneficiary in need of it, except those served by IHS or Tribal facilities and medically frail beneficiaries</p>	1
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Reasons for Disenrollment	<ul style="list-style-type: none"> • Failure to make required premium contributions within sixty (60) days of the date of invoice • Failure to provide the necessary information for the state to complete an annual redetermination • Failure to timely and accurately report a change in circumstance affecting eligibility only in such circumstances where a beneficiary would no longer be eligible for Medicaid 	4	<ul style="list-style-type: none"> • Determined to be medically frail after they were previously determined eligible • Failure to report compliance for 3 months (state will disenroll the beneficiary for the remainder of the calendar year) 	2
Retroactive Eligibility	The state is not obligated to provide retroactive eligibility in accordance with Section 1902(a)(34) for beneficiaries enrolled in Kentucky HEALTH, except for applicants who would have been eligible in or after the third month before the month in which an application was made, as either pregnant women or former foster care youth	2	The state will provide coverage effective 30 days prior to the date of submitting an application for coverage for beneficiaries up to and including 133 percent of the FPL	3
TOTAL SCORES:	Kentucky HEALTH	37	Arkansas Works	36
TOTAL POSSIBLE POINTS:	Kentucky HEALTH	60	Arkansas Works	60

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